Health Services
LOS ANGELES COUNTY

April 21, 2006

TO: Each Supervisor

FROM: Bruce Chernof, M.D.
Acting Director and Chief Medical Officer
Department of Health Services

J. Tyler McCauley
Auditor-Controller

SUBJECT: THIRD REVIEW OF NAVIGANT CONSULTING, INC.'S CONTRACT DELIVERABLES

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The Department of Health Services (DHS) and the Auditor-Controller have completed a third review of Navigant Consulting, Inc.'s (Navigant) compliance with Navigant's contract for consultant services at King/Drew Medical Center (KDMC). We reviewed Navigant's progress in implementing the contract deliverables and a sample of the workplan recommendations made during Navigant's January 2005 facility-wide assessment. The review included interviewing Navigant and DHS/KDMC management and staff, reviewing documentation, and performing testwork to validate implementation progress.

Background

The County's contract with Navigant includes 32 deliverables. Based on one of the deliverables, Navigant developed a detailed action plan (workplan) with 1,066 recommendations to address deficiencies or inefficiencies identified in its assessment of KDMC's systems and operations. Navigant indicated that, since their initial assessment and based on their implementation efforts, there have been additions, deletions, or changes to the initial recommendations. As of the date of our review, there were a total of 1,021 workplan recommendations. The workplan recommendations were separated into categories based on the urgency of the recommended action. The due dates for the Urgent, Short-term, and Intermediate recommendations were February 28, 2005, June 30, 2005, and October 31, 2005, respectively. The Long-term recommendations are to be completed throughout 2006. Navigant reported that 674 (66%) of the 1,021 recommendations had been implemented.

Review of Implementation Status

For this review, we reviewed 19 contract deliverables and 21 workplan recommendations for implementation from contract inception through March 31, 2006. The deliverables reviewed include the remaining contract

deliverables that were not previously reviewed or were reported as in progress during the two prior reviews. The workplan recommendations reviewed also included those previously reported as in progress and a sample of Intermediate recommendations selected based on the importance and risk associated with each recommendation. Except for one recommendation that was reclassified from Urgent to Long-Term subsequent to our first review, the recommendations selected for review were due to have been implemented as of the date of our review. It should be noted that some of the recommendations shown as in progress are considered in progress because they require continuing action during the term of the agreement. The following tables indicate an overall status of all deliverables and current workplan recommendations based on our review:

STATUS OF DELIVERABLES

Total Deliverables	Total Deliverables Implemented (Prior Two Reviews)	Deliverables Reviewed (Third Review)	Deliverables Implemented (Third Review)	Total Deliverables Implemented (All Three Reviews)	Deliverables In Progress
32 [1]	13 [2]	19	9	22 (69%) [3]	10 (31%) [3]

(1) The original contract with Navigant included 35 deliverables. Three of the deliverables were subsequently removed in the first contract amendment.

(2) Fourteen deliverables were reported as implemented in our two prior reviews. However, one of the deliverables was subsequently removed in the first contract amendment. See Footnote (1).

(3) Includes four deliverables for which Navigant was in compliance as of the date of the review. However, since the deliverables require implementation throughout the duration of the agreement, the status of the deliverables is in progress. As of the date of this review, Navigant is in full compliance with **26 (81%) of the 32 deliverables**, including 22 deliverables fully implemented and four deliverables requiring implementation throughout the duration of the agreement.

STATUS OF WORKPLAN RECOMMENDATIONS – THIRD REVIEW

	Total Reviewed	Implemented	% Implemented	In Progress	% In Progress
Urgent	4	2	50%	2	50%
Short-Term	4	2	50%	2	50%
Intermediate	12	8	67%	4	33%
Long-Term [4]	1	0	0%	1	100%
TOTAL:	21	12	57% [4]	9	43%

(4) This recommendation was reclassified from Urgent to Long-Term subsequent to our first review. As a result, the recommendation was not due to be implemented as of the date of this review. Twelve (60%) of the 20 of the recommendations that were due to be implemented as of the date of our review had actually been implemented.

Conclusion

Navigant continues to make progress in implementing the contract deliverables and the workplan recommendations. For example, Navigant continued to perform regulatory readiness activities at KDMC and at the Hubert H. Humphrey Comprehensive Health Center (Humphrey) related to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). As a result, Humphrey received a favorable outcome on their March 2006 JCAHO accreditation survey. However, we noted several issues that Navigant and KDMC need to address to improve clinical and operational deficiencies at KDMC. For example, we noted that Navigant and KDMC are not in full compliance with all human resources standards, have not completed competency assessments for all nursing staff, and are not meeting targeted discharge times for patients. In addition, we noted that Navigant was not always providing the required full-time interim management staff; however, the County has only paid for the interim management staff provided.

Our review of the workplan recommendations continues to show a lower implementation percentage than Navigant has reported. For example, although Navigant reported that 20 (95%) of the 21 recommendations reviewed had been implemented, our review noted that only 12 (57%) of the recommendations were implemented. Navigant indicated that the difference is in part due to the need for on-going monitoring to ensure actions taken continue after initial implementation. In order to ensure the outcomes and work steps stay completed, constant vigilance is required. For example, although computer privacy screens were put in place, we noted that some were missing during this review. In addition, we noted weaknesses in maintaining the residency procedure certification listing. The workplan is the overall performance indicator of the accomplishments made by both Navigant and DHS to make critical changes in the operations of the facility. Prior to the completion of the contract term, KDMC and Navigant will work together to identify the remaining workplan recommendations and evaluate the workplan recommendations that should be implemented or modified as appropriate to continue to address clinical and operational improvements.

Details of our findings and recommendations are included in Attachment I. A copy of the review was provided to both Navigant and KDMC management for their review and comment. KDMC and Navigant generally concurred with our report. Navigant provided a few comments on the draft report, which we considered, and appropriate changes were made. KDMC's response to the results of our review is included as Attachment II to the report. Navigant was given the opportunity to provide additional comment on the final report, but declined to provide further response.

Please let us know if you have any questions.

BC/JTM
Attachments

c: Chief Administrative Officer
County Counsel
Executive Officer, Board of Supervisors
Navigant Consulting, Inc.

ATTACHMENT I

LOS ANGELES COUNTY – DEPARTMENT OF HEALTH SERVICES

AUDIT AND COMPLIANCE DIVISION

- AND -

LOS ANGELES COUNTY AUDITOR-CONTROLLER

SUBJECT: REVIEW OF CONTRACT DELIVERABLES - NAVIGANT CONSULTING, INC.

PURPOSE/BACKGROUND:

Based on issues raised by the Federal Centers for Medicare and Medicaid Services (CMS), the County Department of Health Services (DHS) contracted with Navigant Consulting, Inc. (Navigant) to provide interim management services and a facility-wide assessment at King/Drew Medical Center (KDMC). The contract between Navigant and DHS, including the second amendment, is for approximately $21 million. The interim management services included providing on-site management, such as a Chief Executive Officer, Chief Operating Officer, Chief Nursing Officer, and other key management positions. The facility-wide assessment included developing and implementing recommendations to correct clinical and operational deficiencies at KDMC. The Board of Supervisors designated KDMC's Chief Executive Officer (CEO) to monitor Navigant's performance to ensure obligations under the agreement have been met and review all tasks, deliverables, goods, services, and other work provided by or on behalf of Navigant.

In accordance with the contract, Navigant developed a detailed action plan (workplan) that included 1,066 recommendations to address deficiencies or inefficiencies identified in its facility-wide assessment of KDMC systems and operations. In its initial assessment, Navigant indicated that the workplan is a "living" plan and should be updated to reflect any changes deemed appropriate. The workplan recommendations were separated into categories based on the urgency of the recommended action. The due dates for the Urgent, Short-term, and Intermediate recommendations were February 28, 2005, June 30, 2005, and October 31, 2005, respectively. The Long-term recommendations are to be completed through 2006.

As of the date of our review, the workplan included 1,021 recommendations. Navigant reported that 674 (66%) of the 1,021 recommendations had been completed. Navigant indicated that modifications to the workplan were discussed and reviewed by DHS senior managers and the KDMC CEO.

SCOPE/REVIEW RESULTS:

DHS' Audit and Compliance Division (A&CD), in conjunction with the Auditor-Controller (Auditors), has conducted three reviews of the contract deliverables and workplan recommendations. Our previous reviews noted a total of 13 deliverables have been implemented. For this review, we reviewed a total of 19 contract deliverables and 21 workplan recommendations for implementation from contract inception through March 31, 2006. The deliverables reviewed include the remaining

contract deliverables that were either not previously reviewed, or were reported as in progress during the two prior reviews. The workplan recommendations reviewed also included those previously reported as in progress, and a sample of Intermediate recommendations selected based on the importance and risk associated with each recommendation. Except for one recommendation that had been reclassified from Urgent to Long-term subsequent to our initial review, the recommendations selected for review were due to have been implemented as of the date of our review. It should be noted that some of the recommendations shown as in progress are considered in progress because they require continuing action during the term of the agreement. The following tables indicate the status of the deliverables and current workplan recommendations included in this review:

STATUS OF DELIVERABLES

Total Deliverables	Total Deliverables Implemented (Prior Two Reviews)	Deliverables Reviewed (Third Review)	Deliverables Implemented (Third Review)	Total Deliverables Implemented (All Three Reviews)	Deliverables In Progress
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STATUS OF WORKPLAN RECOMMENDATIONS – THIRD REVIEW

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(4) This recommendation was reclassified from Urgent to Long-Term subsequent to our first review. As a result, the recommendation was not due to be implemented as of the date of this review.

Twelve (60%) of the 20 of the recommendations that were due to be implemented as of the date of our review had actually been implemented.

A&CD and the Auditors interviewed Navigant, Department of Human Resources (DHR), DHS Administration, and KDMC staff and reviewed relevant and available documents to support the findings contained in this report.

REVIEW OF CONTRACT DELIVERABLES

We reviewed a total of 19 contract deliverables. Nine (47%) of the 19 deliverables have been implemented and 10 (53%) remain in progress. Of the 10 deliverables in progress, Navigant was in compliance with the contract for four deliverables as of the date of the review. However, since the deliverables require implementation throughout the duration of the agreement, the status of the deliverables is in progress.

- **Deliverable 1.1**

  Requires Navigant to provide full-time, on-site Chief Executive Officer, Chief Operations Officer, Chief Nursing Officer, Physician Advisor, Senior Pharmacies Consultant, Senior Radiology Consultant, Senior Laboratory Consultant, Senior Medical Records Consultant, and various nurse managers unless released from this obligation.

  Status: **In Progress**

  Auditor-Controller's Finding

  In the previous review, the Auditors indicated that the first contract amendment required Navigant to provide an itemized invoice, along with a certification signed by Navigant's Project Director attesting to the level of services provided. The Auditors noted that Navigant submitted a Contract Reconciliation and listing of "Man Day Equivalents" (MDEs) Navigant claimed were worked from November through July 2005. However, although the first amendment required Navigant to have documentation to support the certification, Navigant did not provide the required documentation (e.g., attendance logs, timecards, etc.) supporting the reported number of MDEs. As a result, the Auditors could not verify the number of MDEs reported by Navigant or whether Navigant was providing the required full-time, on-site staff.

  Since the prior review, Navigant provided the Auditors with timekeeping records, reconciliation reports, and other relevant documentation to support the MDEs worked from June 2005 through February 2006. Navigant indicated that they did not have timekeeping records to support the number of MDEs worked from November 2004 through May 2005.

  The Auditors reviewed Navigant's timekeeping records from June 2005 through February 2006, and noted instances where Navigant did not always provide the required full-time staff. For example, the Auditors noted that from June 2005 through October 2005, the Senior Laboratory Consultant and the Senior Pharmacies Consultant only worked 19% and 33% of

the MDEs expected of a full-time staff. In addition, the Senior Medical Records Consultant only worked 43% of the required time during August 2005. The Auditors are working with DHS to ensure that Navigant is only paid for MDEs actually worked.

Deliverable 1.3 and Deliverable 2.12

To the extent possible, within the limits of Contractor's control, prepare the Hospital to obtain reinstatement of full JCAHO accreditation by December 31, 2005.

Status: **In Progress**

Audit and Compliance Division's Findings

It was previously reported by Navigant that weekly mock surveys were being conducted at KDMC to determine weaknesses in compliance. Navigant indicated that a weekly "dashboard" is used to summarize the progress of initiatives and actions taken for regulatory compliance, which gives a status based on data collected and reported.

As of November 2005, Navigant reported that 11 (92%) of the 12 JCAHO Functions/Standards' Chapters included in the dashboard were in partial compliance and one (8%) related to Accreditation Participation Requirements was not in compliance. The report indicated that this standard could not be met until reaccredidation is established. According to the Regulatory Readiness Committee minutes, members regularly report on the efforts to bring the facility into compliance with CMS and JCAHO standards.

Navigant indicated that the Hospital's primary focus is the CMS survey, which will encompass most of the JCAHO standards as well. Navigant staff indicated that senior managers have been conducting mock surveys/sweeps and debrief the supervisor of the unit reviewed of any findings or concerns identified. Audit staff obtained a list of senior managers and "Questions the Surveyor is Most Likely to Ask Staff" used to conduct the mock surveys. A&CD interviewed three senior managers who confirmed that mock surveys/sweeps and rounds are on-going tools used for regulatory readiness and have currently been completing weekly rounds in anticipation of CMS and/or JCAHO. In addition, KDMC held two employee Regulatory Readiness Fairs in January and February 2006 and distributed Accreditation and Licensure pamphlets that include a guide to prepare for a CMS/JCAHO survey. A&CD conducted a survey of six employees who attended the Regulatory Readiness Fairs, who all stated that the information provided was very informative.

On December 20 and 22, 2005, KDMC and Navigant management staff held a Joint Planning Session that described CMS areas of focus and status of corrective actions. The session also included observations by management staff, survey tips, accomplishments to date, and tracking and communicating progress for each of the conditions of participation subjects.

As of the date of our review, Navigant has provided on-going regulatory readiness activities and, thus, implemented this deliverable. However, since the deliverable requires

implementation throughout the duration of the agreement and JCAHO accreditation has not been reinstated, the status of these deliverables remain in progress.

- **Deliverable 1.4**

Achieve and maintain compliance with human resources standards in accordance with appropriate regulatory requirements throughout the duration of the Agreement.

Status: **In Progress**

Auditor-Controller's Finding

Navigant established the Human Resources workgroup to address the human resources issues that were identified in Navigant's KDMC facility-wide assessment. The workgroup, comprised of DHR, DHS Human Resources, KDMC and Navigant staff, revised 61 Human Resources policies and procedures to conform to appropriate regulatory requirements. In addition, the workgroup developed a Staff Area File Review Checklist to ensure that all staff are in compliance with human resources standards.

The Auditors compared 10 employee personnel files to the Staff Area File Review Checklists to determine whether the files included all applicable items on the checklist. The Auditors noted that nine of the 10 files did not contain all of the required documentation (e.g., missing current performance evaluations, position/job descriptions, Age Specific/Population Competency forms, training, etc.). DHR reviewed the personnel files of all KDMC permanent employees as of October 2005. That review disclosed that 103 (12%) of 868 employees did not have a current performance evaluation filed. DHR is conducting a review of all KDMC personnel files to ensure compliance with all human resources regulatory requirements and standards, including the items listed on the Staff Area File Review Checklist.

The Auditors also noted that the checklist did not include some of the basic nursing credentialing requirements as indicated in KDMC's Departmental Scope of Service.

- **Deliverable 1.5**

By March 1, 2005, develop and thereafter implement a transition plan that replaces Contractors' interim managers with permanent managers so that the corrections can be sustained.

Status: **In Progress**

Audit and Compliance Division's Findings

As noted in the previous review, Navigant provided transition plans for the following Interim Management Services provided: CEO, COO, CNO, and Clinical Nursing Directors (CND) for psychiatry, intensive care, emergency services, medical/surgical services, operating room and maternal-child health, Administrative Director of Radiology, and the Director of Health

Information Management (HIM). DHR further indicated that DHS and Navigant continue to work with DHR to recruit for other administrative positions.

KDMC has filled each of the above positions, with the exception of emergency services and radiology. Although the transition plans were not updated for the specific individuals hired, Navigant indicated that one-on-one orientation and transitioning occurred. The CEO and CNO confirmed that Navigant interim managers provided in-depth orientation and transition of duties and remained available for questions and consultation subsequent to leaving KDMC. In addition, the CNO was provided with an Orientation Book that includes some of the tools that were developed, nursing workplans, and policy and procedure plans, which the CNO continues to use as a guide in performing her duties.

- **Deliverable 1.6**

By September 1, 2005, in consultation with DHS Human Resources staff, recruit, interview, and make recommendations for hire to the County for the positions of: CEO, COO, CNO, Plant Manager, Humphrey Administrator. For all recruitment activities, it is the responsibility of the County to support the cost of recruiting such as travel, screening and, if necessary, the use of outside recruiters.

Status: **Implemented**

Auditor-Controller's Finding

DHR, DHS Human Resources, KDMC, and Navigant participated in the recruitment and hiring of KDMC's CEO, COO, CNO, Plant Manager, and CEO for the Hubert H. Humphrey Comprehensive Health Center (Humphrey Administrator). The Auditors verified that the employees have been hired for these positions.

- **Deliverable 1.7**

Identify gaps in mid-level management positions by March 1, 2005. In consultation with DHS' HR staff, by September 1, 2005, recruit, interview, and make recommendations for hire to the County for positions necessary to fill the management gaps. For all recruitment activities, it is the responsibility of the County to support the cost of recruiting such as travel, screening and, if necessary, the use of outside recruiters.

Status: **In Progress**

Audit and Compliance Division's Findings

KDMC has continued to fill mid-level management positions. For example, the CEO for the Hubert H. Humphrey Comprehensive Health Center (Humphrey), three CND positions, the Pharmacy Director, the Quality Management/Performance Improvement Director and other positions have been filled. Navigant provided a List of Recruitment Activities of continued efforts by DHR and DHS for other management positions at KDMC, including those

identified in Deliverable 1.5. In addition, recruitment efforts continue for other positions, such as Clinical Nursing Specialists, Chief Physicians, and Nurse Managers.

➢ **Deliverable 1.13**

Throughout duration of Agreement, assure that root cause analyses are conducted on all incidents determined to be significant events. Make and implement recommendations to address and resolve personnel and systems issues uncovered by the root cause analyses.

Status: **In Progress**

Auditor-Controller's Finding

A sentinel event is an event that has resulted in, or could have resulted in, an unexpected death or major permanent loss of function, not related to the natural course of a patient's illness or underlying condition. As indicated in the previous review, Navigant had assisted in a retrospective review of all significant events that have occurred at KDMC since January 2005. Navigant's review identified six more sentinel events that required root cause analyses. The Auditors previous review noted that five of the six root cause analyses had been performed. The Auditors current review indicates that the sixth root cause analysis has been completed.

In addition, Navigant continues to participate in daily, morning conference calls with DHS Administration and KDMC management to discuss all significant events that have occurred during the prior work day(s) to identify sentinel events which would require root cause analysis.

As of the date of our review, Navigant has implemented this deliverable. However, since the deliverable requires implementation throughout the duration of the agreement, the status of this deliverable remains in progress.

➢ **Deliverable 1.15**

Review the work previously provided by the Camden Group and continue the ongoing assessment of the competency of nursing staff at the Hospital, institute remediation for those nurses who do not meet standards, and recommend to the COO of DHS personnel actions for those nurses who fail remediation.

Status: **In Progress**

Auditor-Controller's Finding

Navigant indicated that nursing competency assessments include the completion of the Assessment of Competency and Specialized Skills Worksheet (Worksheet), and a review of nursing credentials based on the Required Credentials Grid and Departmental Scope of Service. The Auditors reviewed 18 Nurse Area Files and noted that one (6%) file did not

include a completed competency assessment (e.g., completed during evaluation period and no review/approval signatures).

In addition, the Auditors noted that the Required Credentials Grid did not include some of the basic nursing credentialing requirements for most departmental units as indicated in KDMC's Departmental Scope of Service. The Scope of Service identifies the roles and responsibilities for nursing staff, and includes all the required nursing qualifications and credentials for each unit. Navigant indicated that they are in the process of updating the Required Credentials Grid to reflect the requirements of KDMC's Scope of Service. In addition, DHS Human Resources is in the process of instituting remediation for one nurse.

➢ **Deliverable 1.18**

The interim CNO shall oversee the nursing administration at the Hospital and, in addition to the day-to-day management of that function, the CNO shall evaluate and oversee the implementation of: (1) changes to maximize supervisory coverage of staff and management of quality patient care, (2) the building and sustaining of a culture that supports strong communication between nursing management, nursing employees, physicians, and support staff and, (3) the implementation of the revised Plan for the Provision of Care and ensuring that all standards of practice within the nursing division are met.

Status: **Implemented**

Auditor-Controller's Finding

KDMC appointed a new Chief Nursing Officer (CNO) in November 2005. The Auditors reviewed the responsibilities and job functions of the CNO position, and determined that they appropriately correspond with the requirements indicated in the deliverable. The Auditors also reviewed KDMC's Nursing Services organizational chart, and verified with various nursing directors that significant changes have been made to the structure of Nursing Services, resulting in greater oversight and accountability of nursing staff and management.

In addition, KDMC and Navigant developed and distributed to staff a Departmental Scope of Service, a Standardized Hospital Internal Communication policy, and a Plan for the Provision of Nursing Care that addresses patient care issues, departmental goals, nursing performance, and communication throughout the facility. As noted in the discussion of Deliverable 1.15, the Nurse Area Files generally included all the required documentation.

➢ **Deliverable 1.19**

By January 17, 2005, establish a tutoring and mentoring program for nurse managers, with clearly established skills and management competencies.

Status: **Implemented**

Auditor-Controller's Finding

In August 2005, KDMC, DHR, and Navigant met to discuss and establish the KDMC Nurse Manager Leadership/Teambuilding Project. The project was established to define and develop processes to enhance leadership skills and serve as a positive reinforcement for Nurse Managers at KDMC. KDMC and Navigant also developed Leadership Assessments for Nurse Managers which address the skills and competencies of a successful Nurse Manager and use focus groups, surveys, and observations as part of the program. Navigant indicated that training and coaching sessions will be established on an on-going basis and will be scheduled based on the findings from the assessments. In February 2006, KDMC and Navigant conducted a Charge Nurse Workshop discussing effective communication, work-environments, nursing challenges, and the roles and responsibilities of Nurse Managers.

- **Deliverable 1.21**

By March 15, 2005, review the work previously provided by The Camden Group and, to the extent necessary, complete the review and revision of the nursing policies and procedures to determine the level of appropriateness and compliance with outside regulatory requirements.

Status: **Implemented**

Auditor-Controller's Finding

Navigant developed an updated Nursing Departmental Policy Manual, which includes all related nursing policies established for KDMC. The Auditors discussed the revised nursing policies and procedures with DHS Quality and Improvement (QIP). QIP reviewed the policies and procedures and determined that they were appropriate and comply with outside regulatory requirements.

- **Deliverable 1.22**

The parties recognize that the scope of work to be provided by Contractor does not include Contractor's assessment of financial practices at Hospital. If, however, in performing services under this Task 1, Contractor identifies financial practices that warrant change, Contractor shall make appropriate recommendations to County Project Director for consideration and approval. Contractor shall not implement any such recommendations without County Project Director's approval.

Status: **In Progress**

Audit and Compliance Division's Findings

The deliverable requires Navigant to make appropriate recommendations related to financial practices warranting change if identified during their assessment of KDMC. As of the date of

the review, Navigant, the County Project Director, and KDMC CFO have not identified any workplan recommendations that warrant change to financial practices. However, since this deliverable requires implementation throughout the duration of the agreement, the deliverable is in progress.

- **Deliverable 2.3**

Reduce the number of admitted patients awaiting a bed in the Emergency Department "holding area" (7:00 a.m. snapshot) from the baseline of 19 to 10.

Status: **Implemented**

Audit and Compliance Division's Findings

As reported in the previous review, a daily "snapshot" of the patient census in the Emergency Department is recorded on the "Nursing Daily Activity Report" and is reported in a daily report to the CEO and disseminated to the Senior Leadership staff. The snapshot includes a count of the number of patients located in the Emergency Department "holding" area who have been admitted and are waiting for an available bed.

A&CD noted that the Available Beds report appears to be completed in accordance with the KDMC Bed Availability and Assignment of Beds Policy, No. HA302A. Audit staff reviewed the holding area snapshot trends for the period of July 2005 through January 2006 which indicated that the number of admitted patients waiting for a bed in the Emergency Department holding area averaged less than 10 patients per month, ranging form 10.5 patients in July 2005 to 5.6 patients in October 2005. A&CD confirmed that the average reported number of patients for each month, 9.0, 9.2, and 6.9 for November and December 2005, and January 2006, respectively, was consistent with the number of beds reported on the Daily Activity Reports.

- **Deliverable 2.6**

Improve the percentage of patients (excluding Obstetrics) discharged each day by 12 noon from 2.6% to 10% and implement a plan for continuous measurement and improvement.

Status: **In Progress**

Auditor-Controller's Finding

Navigant developed Discharge Planning and Discharge Times policies and procedures to establish guidelines to expedite patient discharge at KDMC. Navigant also conducted patient discharge and pharmacy studies, and determined that the main reason for discharge delays was a lack of communication between physicians, nurses, social/case workers, and patients, resulting in increased pharmacy turnaround time and patient transportation issues.

The Auditors reviewed Navigant's Performance Measure Report for Patient Discharge, from June 2005 through November 2005. The Auditors noted that Navigant and KDMC have increased the percentage of patients discharged by 12 noon (excluding Obstetrics) from their 2.6% baseline to six percent. However, this increase is four percent less than their 10% target rate. To address these issues, Navigant established a Patient Flow Task Force, comprised of departmental staff involved in the discharge process, to identify areas for improvement and to help reduce patient discharge delays.

- **Deliverable 2.7**

Improve by 50% operating room utilization (by number of minutes of operating room (OR) use/staffed minute) from a baseline of 22% to 33%.

Status: **Implemented**

Audit and Compliance Division's Findings

In its initial assessment, Navigant noted that poor OR utilization reflected excessive available hours based on hours of operation and staffing. Navigant indicated that the utilization of the OR suite is based upon the total case hours and the total available OR hours. In the previous review, it was reported that Navigant indicated that based on the volume of surgical cases, the OR hours of operation were reduced in March, April, June, and August 2005. Navigant reported an increase in OR Suite Utilization from 24% in February 2005 to 34% in July 2005.

Navigant indicated that in September 2005, additional changes were made in the hours of operations to further improve OR utilization. Navigant reported an OR utilization of 39% and 33% for November and December 2005, respectively. Audit staff compared the surgery times for patients recorded in ORSOS, the OR scheduling system, to the Perioperative Compass that summarizes patient statistics in the OR and determined that the total of case minutes reported is consistent with the utilization indicated. Additionally, the Perioperative Compass reported that the utilization met or exceeded the 33% in each of the months of August 2005 through January 2006, with an average of 37%.

- **Deliverable 2.8**

Reduce the length of stay in the Post Anesthesia Care Unit from a baseline of 349 minutes to 240 minutes.

Status: **Implemented**

Auditor-Controller's Finding

The Auditors reviewed KDMC's Perioperative Compass report for January 2006, which summarizes the average length of stay for patients in Post Anesthesia Recovery. They noted that from August 2005 through January 2006, the reported Post Anesthesia Recovery Length of Stay was less than the established baseline. The Auditors also reviewed the Post

Anesthesia Care Unit patient log for January 2006 and verified that the information included on the Compass report was accurate. The average length of stay in the Post Anesthesia Care Unit for January 2006 was 184 minutes, 56 minutes less then KDMC's established baseline. In addition, the Operating Room Governance Committee met in February 2006 to discuss the Perioperative Compass and efforts to improve patient safety and performance.

- **Deliverable 2.11**

One hundred percent of investigations for sentinel events will be initiated within 24 hours.

Status: **Implemented**

Auditor-Controller's Finding

In June 2005, Navigant revised the policies and procedures for Close Calls/Near Miss, Adverse, and Sentinel Event Notification, Reporting and Documentation and Case Review and Response and Root Cause Analyses. The policies establish general guidelines for the reporting, documentation, follow-up, and corrective action of sentinel events, and require that sentinel event and the root cause analysis process be initiated within 24 hours.

As indicated in Deliverable 1.13, Navigant participates in daily, morning conference calls with DHS Administration and KDMC management to discuss all significant events that have occurred during the prior work day(s) to identify sentinel events which would require root cause analysis.

- **Deliverable 2.13**

By February 1, 2005, provide a detailed, written plan for the coordination of administrative and clinical services between Humphrey Comprehensive Health Center and King/Drew Medical Center, including timeframe for implementing the plan to enable the facility to obtain and/or sustain necessary JCAHO accreditation. Contractor will oversee the implementation of such plan by County personnel.

Status: **Implemented**

Audit and Compliance Division's Findings

Navigant indicated that the KDMC Chief Operations Officer (COO) who was hired on December 5, 2005, has been working with Humphrey Administration to prepare for accreditation inspections. The COO indicated that a Periodic Performance Review was completed at Humphrey, which lists deficiencies found and corrective actions. The COO stated that she was involved in three JCAHO readiness meetings per week at the health center and staff have been performing mock surveys. In addition, Regulatory Readiness Fairs were held in 2006 for employees at Humphrey and KDMC to provide updated information on JCAHO compliance. JCAHO conducted a survey of the Ambulatory Health Care Program at Humphrey on March 15-17, 2006 and maintained its accreditation status. The JCAHO

surveyors identified six Requirements for Improvement (RFIs), which is well below the threshold number that would affect accreditation status.

CONCLUSIONS:

1. Of the 32 contract deliverables, 22 (69%) were implemented and 10 (31%) were in progress. As of the date of this review, Navigant is in compliance with 26 (81%) of the 32 deliverables, including 22 deliverables fully implemented and four deliverables requiring implementation throughout the duration of the agreement.

2. Based on the timekeeping records reviewed for the period June 2005 through February 2006, Navigant did not always provide the required full-time staff.

3. Navigant demonstrated on-going regulatory readiness activities have been conducted at KDMC and Humphrey. Humphrey's JCAHO accreditation was sustained in a March 2006 survey.

4. KDMC is not in full compliance with human resources standards. For example, a review of KDMC's personnel files noted that some did not include all the required documentation (e.g., performance evaluations, training, credentials, etc.).

5. KDMC has filled each of the identified interim positions, with the exception of emergency services and radiology.

6. KDMC has continued to fill mid-level management positions and provided documentation of recruitment efforts.

7. A review of 18 Nurse Area Files noted that one (6%) file did not have a completed nurse competency assessment (e.g., completed during evaluation period and no review/approval signatures). In addition, the Required Credentials Grid also did not include some of the basic nursing credentialing requirements for most department units as indicated in KDMC's Departmental Scope of Service.

8. Navigant continues to work towards improving patient discharge time at KDMC. For the period June 2005 through November 2005, Navigant and KDMC have increased the percentage of patients discharged by 12 noon from their 2.6% baseline to six percent. However, this increase is four percent less than their 10% target rate.

RECOMMENDATIONS:

The KDMC Chief Executive Officer should work with Navigant through the contract term to:

1. Ensure Navigant continues to work with DHS and the Auditor-Controller to provide the necessary documentation for the verification of required full-time, on-site staff.

2. Work with DHR, DHS HR, and KDMC to ensure that KDMC achieves and maintains compliance with human resources standards.

3. Continue to work with DHR and DHS HR to recruit and fill the identified permanent managers and mid-level positions.

4. Continue to assure that root cause analyses are conducted on all incidents determined to be significant events and make and implement recommendations to address and resolve personnel and systems issues uncovered by the root cause analyses.

5. Continue to assess the competency of nursing staff. In addition, Navigant should ensure that the Required Credentials Grid reflects all the requirements indicated in KDMC's Scope of Service.

6. Continue to work with KDMC departmental staff to decrease delays in patient discharges.

REVIEW OF THE ASSESSMENT WORKPLAN

We reviewed a total of 21 workplan recommendations. Based on our review, twelve (57%) of the 21 recommendations have been implemented and nine (43%) are in progress.

The following is the detailed status of the nine Urgent and Short-Term recommendations and action steps that were previously reported as partially implemented or not implemented, including one which was subsequently reclassified as a Long-Term recommendation, and therefore was not due to be implemented as of the date of this review. We reviewed an additional 12 Intermediate recommendations that were due to be completed by October 31, 2005. Not included are the details for the Intermediate recommendations that have been fully implemented.

- **Recommendation S02-I05-R002**

  At a minimum, revise Improve Organization Performance (IOP) Committee membership to a 15-member group that assesses departmental Performance Improvement (PI) reports.

  Status: **Implemented**

  Action Steps

  1. Explore feasibility of integrating quality oversight committee of board with current committee. (Implemented)
  2. Review current bylaws. (Implemented)
  3. Ensure structure is consistent with bylaws. (Implemented)
  4. Propose amendment to bylaws if required. (Implemented)
  5. Obtain medical staff approval on amended bylaws. (Implemented)
  6. Obtain Board of Supervisors, DHS and Advisory Board's approval on amended bylaws as required. (Implemented)

  Audit and Compliance Division's Findings

  Previously it was reported that the structure of the committee was not consistent with the Professional Staff Association (PSA) bylaws, and amendments had not been finalized and approved.

  On December 13, 2005, the Board of Supervisors approved the amendments to the PSA bylaws, which included the performance improvement structure. Navigant indicated that the PSA IOP Committee was reorganized into the Physician Performance Improvement Committee (PPIC) with the responsibility to identify and refer potential problems in the physician component of care, approve plans to improve patient care, assist in meeting JCAHO requirements, oversight of department peer review, and report to the Executive Committee and Governing Body. The hospital-wide component was incorporated into the Quality Circle (QC) and the Quality Performance Improvement Committee (QPIC), which are responsible for quality, performance improvement, and patient safety according to the 2006 KDMC Quality Performance and Improvement Plan.

A&CD reviewed the QPIC membership roster and the PPIC charter, which supports the establishment of the committees, however, the QC and QPIC committees have not yet met in this capacity. In addition, as noted in the prior review, the quality and performance improvement oversight was previously the responsibility of the KDMC Hospital Advisory Board.

- **Recommendation S03-I01-R007**

Identify care management responsibilities by role and establish performance expectations and indicators.

Status: **Partially Implemented**

Action Steps

1. Develop model. (Implemented)
2. Inform and train staff as appropriate. **(Partially Implemented)**

Audit and Compliance Division's Findings

Navigant indicated that a Scope of Service for the unit has been developed which identifies positions and the requirements necessary to fill the positions. Job Descriptions have been developed for each item and a Director has been appointed to assume the responsibility of this area. The Director indicated that she is conducting further research for a model that integrates Case Management for inpatient and outpatient clients and will involve the teamwork of Social Services, Case Management, Utilization Management and Quality of Care. The Director and the Utilization Management Nurse Supervisor indicated that the performance expectations have not been provided to staff and the planned centralization of Quality Assurance, Utilization Management, Care Management and Case Management has not yet occurred.

- **Recommendation S04-I01-R010**

Conduct Medical Director performance review approximately February 2005 in context of interim goals developed December 2004.

Status: **Implemented**

Action Steps

1. Collect review feedback. (Implemented)
2. Review progress on Goals and Objectives. (Implemented)
3. Develop and present review. (Implemented)

Auditor Controller's Findings

The Auditors reviewed the Medical Director's performance evaluation for the period November 2004 through October 2005. The performance evaluation was completed by KDMC's CEO with feedback provided by the interim Navigant CEO. The KDMC CEO reviewed the performance evaluation with the Medical Director in December 2005. In addition, the Auditors verified that the KDMC CEO reviewed the Medical Director's progress in meeting the established Goals and Objectives.

- **Recommendation S04-I02-R037**

Assess accreditation status and outstanding citations of existing residency and fellowship programs; identify approaches to address program gaps within KDMC and/or in partnership or collaboration with other local facilities.

Status: **Partially Implemented**

Action Steps

1. Assess gaps and develop/implement plans to address gaps. (Implemented)
2. Review programs and services regarding scope/service and available staffing. (Implemented)
3. Develop plans to close gaps and implement plans. **(Partially Implemented)**

Audit and Compliance Division's Findings

A Task Force On The Future of Drew Residency Training reported that recommendations were presented to Drew faculty and Residents on July 29, 2005. The recommendations were reviewed by the GME Committee for comments and recommendations. The Drew Board of Trustees met on August 3, 2005 and made final recommendations regarding the program. Recommendations included the reduction in the current resident complement in many of the programs. For example, Anesthesiology would merge with Harbor-UCLA and be reduced from 21 residents to 16.

Dr. Hanna informed A&CD that the proposed resident complements will take effect over a three-year period as Residents complete or leave the programs. For example, the program that currently has 36 Residents, including 12 in each year of the program, will only include ten new Residents for the next program year. Therefore, the recommended changes are in progress and will be fully implemented as current complement of Residents completes the programs. Dr. Hanna further indicated that following the appointment of the new President of Drew University, the Task Force will review and make further recommendations as needed.

➢ **Recommendation S04-I02-R045**

Complete residency supervision protocols by specialty by year and implement consistently.

Status: **Partially Implemented**

Action Steps

1. Review existing "Supervision of Residents" administration policy and revise as necessary to ensure that all overall resident supervision requirements are addressed from a regulatory standpoint. (Implemented)
2. Obtain necessary approval of revised "Supervision of Residents" administration policy from Medical Executive Committee and CEO. (Implemented)
3. Ensure that all necessary documentation of the "Supervision of Residents" policy revisions and their approval, including all signatures, is completed and filed according to protocol. (Implemented)
4. Distribute updated documents to chairs. (Implemented)
5. Work with individual department chairs to ensure that residency supervision protocols are outlined and finalized by specialty, by training year and include all supervision requirements as outlined in the "Supervision of Residents" administrative policy. **(Partially Implemented)**
6. While developing supervision protocols, consider needs for implementing a monitoring process for the proctoring/supervision requirements. (Implemented)
7. Review and finalize, including any necessary approvals, all departmental residency supervision policies and procedures. (Implemented)
8. Following all necessary revision and approval, finalize documentation of new residency supervision policies and disseminate information, including effective date(s), to all necessary parties. (Implemented)
9. Work with training group (GME) to identify all individuals (residents, attending physicians and faculty) who need to receive orientation on revised residency supervision policies and discuss training options. (Implemented)

Audit and Compliance Division's Findings

In the Phase II review, it was reported that DHS QIP reviewed the KDMC Resident Supervision Policy and attachments that were approved in June 2005 and determined that the general supervision policy met or exceeded the requirements of the DHS Supervision Policy No. 310.2. However, QIP noted deficiencies in the resident procedure (prerogative) list containing detail on the specific procedures that residents in each specialty service are allowed to perform. In reviewing the list, QIP identified deficiencies such as the designation of "ARS" (defined as always requiring (direct) supervision), which did not differentiate the type of direct supervision required for a consultation versus the performance of an invasive procedure; the document did not always delineate supervision requirements for interns, PGY 3, or for the different years in a fellowship; and designations of "APPD" (defined as "as per program director"; however, the program director's delineation of prerogatives was not included. The former DHS Senior Medical Director concurred with QIP's findings.

Navigant provided an Invasive Procedure Certification Manual, which includes a listing of the procedures each Resident has been certified by the respective programs to perform without direct supervision. Dr. Nancy Hanna, Director Graduate Medical Education (GME), indicated that the list was compiled by the GME office in February 2006 and will be updated quarterly. She stated the listing has been provided to each of the service areas and is available on-line to identify the procedures each Resident can perform. Dr. Hanna indicated that Navigant, Medical Administration, and the Program Directors worked together to determine the required number of procedures to be competently performed for certification for each procedure and for each specialty. However, as noted previously, she stated each program director determines the particular certification protocol with oversight from GME.

A&CD reviewed a program-specific Resident Procedure List provided by one of the Program Directors. The list includes the level at which competency would be demonstrated (e.g., 1st, 2nd or 3rd year), the required number of procedures competently completed to be certified for each procedure, and tracks the procedures that the Resident proficiently demonstrated (including those designated as ARS). The Resident Procedure List is provided to GME for use in compiling the certification list. A&CD compared one Resident's Procedure List with the certification listing and noted two of the 25 procedures included had been designated as always requiring supervision and, therefore, should not have been included. Dr. Hanna confirmed that the procedures should not be included on the certification listing for the Resident. She indicated that the GME would review the certification listing for each Resident in that program, as well as auditing other programs.

- **Recommendation S05-I12-R001**

Standardize policy, procedure and equipment for Code Blues.

Status: **Implemented**

Action Steps

1. Review and revise Code Blue policy and procedure to include defined areas for Code Blue response versus 911 response. (Implemented)
2. Standardize code carts and contents. (Implemented)
3. Determine cart exchange system. (Implemented)
4. Educate and train all staff on policy changes, roles and responsibilities. (Implemented)
5. Develop monitoring system to evaluate code blue effectiveness. (Implemented)
6. Develop code blue review team. (Implemented)
7. Review all code blues at monthly cardiac arrest committee. (Implemented)

Audit and Compliance Division's Findings

A&CD reviewed the revised Code Blue Policy and Procedures that include defined areas for Code Blue response versus 911 responses and included the Composition of the Code Blue team.

A&CD staff reviewed documentation of the location and contents of standardized code carts. According to Navigant, the carts are sent to Central Supply for cleaning, then transported to Pharmacy to be filled with the appropriate medicine (non-narcotics) and Respiratory Therapy to be filled with appropriate equipment and locked, and then sent to its identified location. Nursing Staff/Clinical Staff are responsible for overseeing the carts function and timely replacement. A&CD staff observed the exchange of a used crash cart and the receipt of a replacement crash cart on 4A, Medical/Surgical Floor Inpatient, which was consistent with the process described.

Navigant provided A&CD staff with copies of attendance sign-in sheets relating to a Program/Course entitled AHA Code Blue Forms, which included a review of the revised Code Blue Policy, roles and responsibilities, Guidelines for completing the National Registry of Cardiopulmonary Resuscitation Event Record and crash cart procedures. A&CD staff surveyed 11 staff members from four units, who were knowledgeable of policy changes, roles and responsibilities.

A&CD noted that code blue topics are monitored by the Cardiac Arrest Committee. The Committee's follow-up and recommendation reports for October and November 2005 indicated on-going review/monitoring of various Code Blue topics.

➢ **Recommendation S05-I15-R009**

Conduct unit-base competency assessment and training relative to the monitors.

Status: **Partially Implemented**

Action Steps

1. Conduct competency assessment for each unit. **(Partially Implemented)**
2. File the assessment result. **(Partially Implemented)**
3. Roll out training for each unit in conjunction with the new monitors installation. **(Partially Implemented)**

Auditor Controller's Findings

KDMC utilizes patient monitors provided by Philips Electronics in the Telemetry, Critical Care, Emergency Room, and Intensive Care Units. In addition to providing the monitors, Philips supplied competency assessment tools and administered training to KDMC staff. However, Navigant indicated that KDMC staff are responsible for conducting the competency assessments and filing them in the area personnel files.

The Auditors reviewed competency assessments of 17 nurse area files and noted that one (6%) did not have completed competency assessments on file. The Auditors also noted that nine (53%) of the 17 were not properly filed in the Nurse Area File. These nine assessments were subsequently provided to the Auditors. In addition, the Auditors noted that one (8%) of

13 nurses reviewed had no record of receiving training on how to appropriately use the monitors.

➢ **Recommendation S05-I15-R010**

Review and revise appropriately policies that relate to the assessment and reporting of potential abuse relating to patients.

Status: **Partially Implemented**

Action Steps

1. Review the current policy and revise as appropriate. (Implemented)
2. Obtain approval and educate staff as necessary. **(Partially Implemented)**

Audit and Compliance Division's Findings

A&CD staff received a copy of the approved signed policy. Navigant presented A&CD staff with copies of sign in logs for staff that attended a training entitled 'Charting by Exception and Introduction to New Forms.' According to Navigant, the training relates to the assessment form for admitted patients, which includes assessing for and documenting suspected patient abuse. Navigant stated that attendees received a documentation handbook at the end of the training that covered all of the material discussed in the training session. A&CD reviewed the handbook and noted instructions for completing the assessment forms indicates that some questions require follow up action, such as for patient at risk to fall. Navigant indicated that suspected abuse would be another example that would require further action or follow up.

A&CD staff reviewed 15 patient chart files from four units and the Adult Initial Assessment forms were found in 13 (87%) of the files. The form has questions that relate to possible abuse, which would require a referral to Social Services if the patient answered, "yes" to these questions. However, since suspected abuse was not identified on the assessment forms in the records reviewed, there were no referrals to Social Services noted. A&CD staff surveyed staff and determined that although staff did not recall attending the Charting by Exception training and were not familiar with Adult Initial Assessment forms, staff indicated that suspected abuse is reported to the Charge Nurse, and the Charge Nurses interviewed indicated suspected abuse is referred to Social Services.

A&CD staff interviewed two Clinical Social Workers who indicated that the Nursing/Clinical staff are responsible for immediate documentation and reporting of suspected patient abuse to the Department of Social Services. However, the Social Workers indicated that staff are not reporting incidents in a timely manner and provided an example from early March 2006 that was not reported until four days after the patient was admitted. Although training regarding patient assessments, including abuse, was documented, training of reporting abuse was not identified.

- **Recommendation S06-I06-R006**

Ensure Occupational Therapy is doing Activities of Daily Living Assessments.

Status: **Implemented**

Action Step

Following hiring of additional registered Occupational Therapists (OTR), develop plan to ensure that they are completing Activities of Daily Living Assessments when appropriate.

Audit and Compliance Division's Findings

In the last review, the Occupational Therapy (OT) Chief indicated that she is monitoring a sample of the charts monthly and the billing records daily. The OT Chief indicated that the Daily Living Assessments are completed in 99% of the patients. Navigant provided Inpatient Psych Assessment - Clinical Pertinence Review reports that indicates, "An activities of daily living assessment completed" 100% for 83 charts reviewed in December 2005 and 100% for 65 charts reviewed in January 2006.

DHS QIP staff reviewed 20 medical records that were randomly selected from 33 discharges for the months of October and November 2005. The OT Assessment form was reviewed and QIP staff found that daily documentation of patient behaviors is 97% (582 documented days/602 days of stay). Daily documentation of OT interventions is 97% and documentation of weekly summery of behaviors and interventions is 100%.

- **Recommendation S06-I07-R001**

Establish a dedicated Triage staff. Call the physician with the disposition.

Status: **Partially Implemented**

Action Steps

1. Discuss triage process and resources with Chief of Psychiatry. (Implemented)
2. Develop a triage model. (Implemented)
3. Hire necessary staff dedicated to triage. **(Partially Implemented)**

Auditor Controller's Findings

As indicated in the previous review, DHR and Navigant were in the process of hiring two additional full-time employees as Triage staff. However, since the last review, Navigant indicated that two Clinical Nurse Specialists resigned, and that there are currently no Clinical Nurse Specialists performing the Triage function in Psychiatry. Navigant and KDMC indicated that physicians are currently performing the triage intake function. KDMC

indicated that this practice will continue until management determines a better model for triage intake.

➢ **Recommendation S07-I06-R005**

Assess the location/orientation of monitor screens throughout the hospital to make sure that patient confidentiality is maintained.

Status: **Partially Implemented**

Action Steps

1. Identify workstation monitor screens (location and/or orientation) that need screen filters. (Implemented)
2. Apply filter screen or view blocker for those monitors identified by action step 1. **(Partially Implemented)**

Audit and Compliance Division's Findings

Navigant provided a memo dated March 3, 2006 from KDMC HIPAA Security/Privacy coordinator, which indicated an assessment of the areas that need privacy screens placed on computer monitors. The memo indicated that privacy screens have been replaced more than once in various areas. A&CD reviewed purchase requests (HS2s) for privacy screens ordered between December 2003 and October 2005.

A&CD conducted a walk through of several units and clinics and confirmed that the security screens were missing on some of the monitors. A&CD reviewed a March 17, 2006 HS2 for 55 privacy screens, which had been subsequently completed to replace missing screens. The Chief Information Officer (CIO) indicated that as a result of identifying privacy screens are being removed, the issue of missing, worn or damaged security screens was discussed in the March 14, 2006 Senior Staff Meeting. The CIO further indicated that the Senior Managers determined that the Charge Nurses would be responsible for monitoring and reporting if the security screens have been removed or damaged and they are in the process of developing a procedure for the Charge nurse to document their findings.

➢ **Recommendation S08-I06-R038**

Perform comprehensive review of each on-site and off-site clinic to determine patient flow, record control, scheduling, financial screening, and space and clinic support personnel issues. Develop an action plan to correct identified problems.

Status: **Partially Implemented**

Action Steps

1. Schedule review of on-site and off-site clinic, including interviews with key medical staff and managers. (Implemented)
2. Review each clinic and identify issues. (Implemented)
3. Develop a detailed action plan and implementation schedule for improvements and changes in policy and procedure. **(Partially Implemented)**

Audit and Compliance Division's Findings

As noted in the previous review, an action plan has been developed, however, the implementation schedule had not been determined. Navigant indicated there has been no change to the action plan, but the KDMC COO has been working closely with Humphrey staff regarding regulatory compliance. According to the County Wide Timekeeping and Payroll Personnel System, CEO of Humphrey was hired on August 8, 2005 but was on leave from January 23, 2006 through March 12, 2006. The COO continued to work with Humphrey towards JCAHO readiness.

The COO indicated that a Periodic Performance Review was completed at Humphrey, which lists deficiencies noted and corrective actions. The COO stated that she was involved in three JCAHO readiness meetings per week at the health center and meets weekly with Humphrey staff. She further stated that staff has been performing mock surveys and Regulatory Readiness Fairs were held in 2006 for employees to provide updated information on JCAHO compliance. Although a written plan and implementation schedule has not been provided, it appears that regulatory readiness activities have been ongoing.

- **Recommendation S10-I03-R030**

Evaluate alternatives for improving quality, patient safety and service delivery, including outsourcing.

Status: **Partially Implemented**

Action Steps

1. Hire Interim DOP. (Implemented)
2. Create a Request for Proposal (RFP) for outsourcing the pharmacy department. **(Partially Implemented)**
3. RFP reviewed and approved by County legal department. **(Not Implemented)**
4. Receive proposals and review. **(Not Implemented)**
5. Issue request for presentations/interviews to top candidate(s). **(Not Implemented)**
6. Internal debrief and review of top candidate(s) presentations/interviews. **(Not Implemented)**
7. Award contract. **(Not Implemented)**

Audit and Compliance Division's Findings

It was previously reported that Navigant submitted an initial draft RFP for review by DHS Management. However, it was returned to Navigant for revision. DHS Administration indicated that a meeting to discuss the documents and workload figures subsequently submitted by Navigant was held and DHS continues to work with Navigant regarding the County's solicitation process.

Navigant indicated that a Request for Information (RFI) was submitted and is being reviewed by the County's Internal Services Department (ISD) and DHS, and a budget allocation was submitted to KDMC Finance. In September 2005, the former Interim CEO, Hank Wells, approved a time frame change from an Urgent recommendation due on February 28, 2005 to Long Term through 2006, as it is dependent of the RFI development, release and responses. The Workplan Change Log indicates that Navigant's request to eliminate the recommendation was denied, however, the log does not indicate who in DHS approved the time frame change. As a result of the change, Action Steps 3-7 indicate that the due date is to be determined. Navigant indicated that the recommendation was not completed; therefore, audit staff did not conduct additional review.

CONCLUSIONS:

9. Of the 21workplan recommendations reviewed, 12 (57%) were implemented and 9 (43%) were in progress. However, since the due date for implementation of one Urgent recommendation previously determined to be partially implemented was subsequently revised to a Long Term recommendation, the recommendation was not due to be implemented as of the date of our review. Therefore, 12 (60%) of the 20 recommendations due as of the date of our review were implemented.

10. The Director of Utilization Management is reviewing the care management model and staff have not been informed of the performance expectations.

11. Proposed programmatic changes in resident complements will take effect over a three-year period as Residents complete or leave the programs.

12. Supervision of Residents protocol has been developed, however, the Invasive Procedure Certification Listing is not consistent with the program(s) specific protocol.

13. All KDMC nurses have not received a competency assessment or training relative to the patient monitors.

14. Based on interviews, staff do not always report potential abuse in a timely manner and training for reporting abuse was not identified.

15. Navigant and DHS are evaluating the best methodology to perform the triage function.

16. Computer monitors were identified that do not have required privacy screens. Although screens have been previously purchased and installed, there was no mechanism in place to monitor use of the privacy screens and replacement when needed to maintain privacy of patient information.

17. An action plan for improvements and changes in policy and procedures for the on-site and off-site clinics has been developed, however, the implementation schedule had not been determined.

18. Navigant indicated that an RFI was submitted and is being reviewed by ISD/DHS for the potential outsourcing the pharmacy department.

RECOMMENDATIONS:

The KDMC Chief Executive Officer should work with Navigant through the contract term to:

7. Continue to work towards implementing all recommendations specified in its Assessment workplan, including the Urgent, Short Term, and Intermediate and ensure that adequate follow-up and documentation is maintained. In addition, the CEO should review and reevaluate the workplan recommendations to implement and/or modify as appropriate to continue to address clinical and operational improvements.

8. Continue to conduct unit-base competency assessments and training on how to appropriately use patient monitors.

9. Work with DHS to determine the methodology to perform the triage function.

10. Ensure that privacy of patients' protected health information is maintained and comply with privacy regulations.

KING/DREW
MEDICAL CENTER

Antionette Smith Epps
Chief Executive Officer

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To improve health through leadership, service and education

April 6, 2006

TO: Sharon Ryzak, Chief
Audit and Compliance Division

FROM: Antionette Smith Epps
Chief Executive Officer

SUBJECT: **NAVIGANT CONSULTING, INC. – PHASE THREE REPORT**

I have reviewed the Phase Three Navigant Report that was prepared by Audit and Compliance Division of DHS and the Auditor-Controller of LA County. I generally concur with the conclusions and recommendations of the report. The leadership of KDMC is developing a plan to continue monitoring and implementation (where appropriate) of the remaining "deliverables" of the Navigant work plan upon the conclusion of the engagement. Since the work plan document itself is approaching two years old, there are a number of work plan items which are no longer applicable.

Please let me know if you have questions or wish to discuss.

ASE:es

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To improve health through leadership, service and education.

April 17, 2006

TO: Antionette Smith Epps, Chief Executive Officer
King/Drew Medical Center

FROM: Sharon Ryzak, Chief
Audit and Compliance Division

SUBJECT: **NAVIGANT CONSULTING, INC. - PHASE THREE REPORT**

This is in response to your April 6, 2006 memorandum regarding the corrective actions taken to address the subject matter.

Based on our discussion and the information provided, it appears that appropriate corrective actions have been taken or are in progress. Please keep my office informed of the implementation of the report's specific recommendations. In addition, once developed, please advise my office of your plan for continued monitoring and implementation of the applicable workplan recommendations.

Your attention to this matter is appreciated.

SR:sm

c: Bruce A. Chernof, M.D.
Paula Packwood

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